Alaska Department of Revenue Permanent Fund Dividend Division

Medical Treatment Verification for Calendar Year 2009

| PFD Division Use Only | | | | | | | |
|-----------------------|--|--|--|--|--|--|--|
| 20100 | | | | | | | |
| | | | | | | | |

On your 2010 Permanent Fund Dividend application, you said you were absent from Alaska for continuous medical treatment. To be an allowable absence, medical treatment must be continuous, on the advice of a licensed physician, and not based on the need for a climatic change.

In order for the Department of Revenue to complete the processing of your 2010 application, you must have your physician complete the information below. You must sign the release before you return it to us. If your medical absence was **not** continuous or was **not** on the advice of a licensed physician, please attach an explanation for claiming this absence.

Applicant: I authorize the physician listed below to release information regarding my medical absence to the Alaska Department of Revenue.

| Printed Name of Patient (Applicant) | Social Security Number | | Date of Birth |
|-------------------------------------|------------------------|----------|---------------|
| Signature of Patient (Applicant) | Date | Telephoi | ne Number |

You must provide the requested information within 30 days after the date of this request. If you do not, your application will be denied in accordance with 15.AAC.23.173(d).

Physician: This is to certify that the patient (applicant) named above is a patient in my care and I recommended or provided treatment for the patient outside of Alaska. This patient received continuous medical treatment during **calendar year 2009** as outlined below. Treatment was not based on a need for climatic change.

Continuous Medical Treatment Reason for Referral Location of Treatment --- Began --- --- Ended ---

| Month | Day | Year | Month | Day | Year | | | | |
|------------------------|---------------------------|--------------------|--------|-----|------|----------------------|--|--|--|
| Month | Day | Year | Month | Day | Year | <u> </u> | | | |
| Signature of Physician | | | | | | Date | | | |
| | Printed Name of Physician | | | | | | | | |
| | Mail | ing Address of Phy | sician | | | Telephone Number () | | | |

Send this completed form to: Alaska Department of Revenue

Year

City, State, Zip Code

Month

Day

Alaska Department of Revenue Permanent Fund Dividend Division PO Box 110462 Juneau, Alaska 99811-0462

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Month